State of New Jersey
Department of Labor and Workforce Development
Division of Workers' Compensation
PO Box 381
Trenton, New Jersey 08625-0381

WC(F)-367 (R-7-04)

RESPONDENT'S ANSWER TO CLAIM PETITION

CASE No. _____

D.O. _____

PETITIONER

SOCIAL SECURITY NUMBER

NAME

ADDRESS (Including County)

ATTORNEY FOR RESPONDENT

❑ NEW JERSEY REGISTRATION NUMBER ❑ SSN ❑ FEDERAL EMPLOYER ID NUMBER

NAME

ADDRESS

TELEPHONE (Area Code)

VS

RESPONDENT

NAME

ADDRESS (Including County)

INSURANCE CARRIER

NAME (indicate if Not Covered or self-insured)

ADDRESS

CARRIER'S CLAIM FILE NUMBER

IN ANSWER TO CLAIM PETITION IN THIS CAUSE RESPONDENT STATES:

Correct name of Respondent if incorrect	Petitioner was in employment on date alleged in petition	Date of accident	Arose out of and in the course of employment	Employment was covered by Article 2 R.S. 34:15
1.	2. ❑ Yes ❑ No	3.	4. ❑ Yes ❑ No	5. ❑ Yes ❑ No

6. How injury occurred

7. Where injury occurred

8. Nature of injury or disease

9. Petitioner's occupation

10. Petioner was furnished medicial treatment ❑ Yes ❑ No

11. Date respondent had knowledge and notice of injury	12. Date petitioner stopped work	13. Date returned to work	14. Gross weekly wage	15 Rate of compensation	16. Temporary Disability paid

17. Permanent disability paid ❑ or being paid ❑

_____ %of _____ @ _____ weeks totaling _____

18. Respondent rendered aid to the petitioner by the following individuals and/or institutions:

Other pertinent information: (Use reverse side if necessary)

The Respondent reserves the right to cross examine all physicians upon whom the petitioner will rely in proof of the claim.

❑ Demand is hereby made for answers to standard occupational disease interrogatories.

❑ Demand is hereby made for all records of medical treatment, examinations and diagnostic studies.

I certify that the foregoing statements made by me are true to the best of my knowledge, information and belief.

_____ _____

Attorney for the Respondent or Respondent's Insurance Carrier — Date